

**MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER**

September 10, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 2100, HOME AND COMMUNITY-BASED WAIVER  
(HCBW) FOR PERSONS WITH MENTAL RETARDATION AND  
RELATED CONDITIONS

**BACKGROUND AND EXPLANATION**

Revisions to Medicaid Services Manual (MSM) Chapter 2100 are being proposed to bring this chapter in line with the current waiver renewal which was approved on January 10, 2014. Changes to this chapter include a name change throughout the entire chapter from Waiver for Persons with Mental Retardation and Related Conditions to Waiver for Individuals with Intellectual Disabilities and Related Conditions. In addition, changes were made throughout the chapter to change Intermediate Care Facilities for the Mentally Retarded (ICF/MR) to Individuals with Intellectual Disabilities (ICF/ID). These changes bring the State in line with Federal requirements on the correct terminology: Individuals with Intellectual Disabilities.

Many services were reworded and updated for clarity. The provider qualifications and recipients rights sections were streamlined and clarified. Outdated language was either removed or reworded for clarity.

In July of 2013, Mental Health and Developmental Services (MHDS) was merged into Aging and Disability Services Division (ADSD). Throughout the chapter, references to MHDS were changed to ADSD.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective October 1, 2015.

**MATERIAL TRANSMITTED**

MTL 20/15  
CHAPTER - 2100 HOME AND COMMUNITY -  
BASED WAIVER SERVICES FOR  
INDIVIDUALS WITH INTELLECTUAL  
DISABILITIES AND RELATED CONDITIONS

**MATERIAL SUPERSEDED**

MTL 08/10, 27/11, 49/10  
CHAPTER - 2100 HOME AND  
COMMUNITY - BASED WAIVER  
(HCBW) FOR PERSONS WITH  
MENTAL RETARDATION AND  
RELATED CONDITIONS

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>2100</b>	<b>Introduction</b>	<p>Updated waiver name and appropriate agency here and throughout the entire chapter.</p> <p>Consolidated provider responsibilities and recipient responsibilities from multiple sections throughout to one section, with exception to provider specific requirements.</p>
<b>2101</b>	<b>Authority</b>	Removed outdated authorities or authorities that do not have to do with a home and community based waiver.
<b>2103.1A.1</b>	<b>Coverage and Limitations</b>	Clarified - through the Division of Welfare and Supportive Services. Cleaned up language throughout this section.
<b>2103.1A.9</b>		Added reference that legal guardians must provide verification that they cannot provide services and that legal guardian of individuals 18 and over are considered Legally Responsible Individual (LRI's).
<b>2103.1A.11</b>		
<b>2103.2</b>	<b>Waiver Services</b>	<p>Updated wording, no change to policy.</p> <p>Removed #7 – Community Integrations Services, no longer a waiver service and added a new waiver service, Career Planning.</p>
<b>2103.2A</b>	<b>Provider Responsibility</b>	<p>Removed paragraph (number c) reference to participant direction as it no longer offered under this waiver.</p> <p>Clarified enrollment and certification requirements. Many of the requirements are verified by ADSD, so ADSD's certification letter is acceptable for enrollment.</p> <p>Changed and clarified certification, not licensure.</p> <p>Consolidated and moved provider responsibilities to one section.</p> <p>Deleted insurance requirements as these are specific the ADSD certification process. ADSD is currently working with Risk Management to clarify amounts and type of insurance required.</p>

		Clarified criminal background checks and deleted old language, and added new language.
		Added section for documentation requirements for this waiver, and removed reference and requirements for “daily record”. Daily record does not fit the documentation requirements of this waiver. Clarified what needs to be included in provider documentation.
		The Serious Occurrence Form was recently updated the language of this section to match form. This is clarification. This is not a policy change; just a clarification of what is required to be reported.
		Updated language for how to report abuse and neglect by age group.
		Updated language for employee files and what must be included in those files. There is not policy change, just updated language.
<b>2103.2B</b>	<b>Recipient Responsibilities</b>	Updated wording from authorized representative to personal representative in all places in this section and throughout the chapter. This is updated language.
		Updated daily record to service documentation, updated language.
		Included examples of required documents for signature, recipient rights and statement of choice.
<b>2103.3A</b>	<b>Coverage and Limitations</b>	Added reference to MSM 2500, Targeted Case Management.
<b>2103.4</b>	<b>Day Habilitation</b>	Reworded and clarified service description. This is not a change to policy, just updated language.
<b>2103.4A</b>	<b>Coverage and Limitations</b>	Reworded and clarified with updated language.
<b>2103.5</b>	<b>Residential Support Services</b>	Changed the name and reworded service to provide more clear guidance of what this service is intended to do.
<b>2103.5A</b>	<b>Coverage and Limitations</b>	Reworded: Residential Support Services.
		Clarified entire section to provide clarity. Included building of natural support networks.
		Clarified medication administration certification process.

		<p>Added g. Providing assistance with support and skill training in health care needs and h. Facilitation of mobility training, survival and safety skills.</p> <p>Updated and clarified residential support services.</p> <p>Reworded and clarified host homes.</p> <p>Reworded and clarified residential support services.</p> <p>Removed section reference to participant direction as it no longer offered under this waiver.</p>
<b>2103.6A</b>	<b>Prevocational Services</b>	<p>Reworded: Prevocational Services.</p> <p>Clarified entire section to provide clarity.</p> <p>Removed outdated language under coverage and limitation and reworded for clarity.</p>
<b>2103.7</b>	<b>Supported Employment</b>	<p>Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.</p>
<b>2103.8</b>	<b>Behavioral Consultation, Training and Intervention</b>	<p>Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.</p> <p>Added Functional Behavioral Assessment.</p> <p>Clarified service limitation and requirements if limit is exceeded.</p>
<b>2103.9</b>	<b>Community Integration Services</b>	<p>Removed entire section as this is no longer a service provided under this waiver.</p>
<b>2103.9</b>	<b>Counseling Services</b>	<p>Renumbered, new #9. Reworded this section for clarity.</p> <p>Added: Counseling Services are provided based on the participant's need to assure his or her health and welfare in the community; and Added: individual and group services; assessment/evaluation process; therapeutic intervention strategies; risk assessment; skill development; psycho-educational activities and deleted outdated language.</p>
<b>2103.9A</b>	<b>Coverage and Limitations</b>	<p>Clarified service limitation and requirements if limit is exceeded.</p>

<b>2103.9B</b>	<b>Counseling Services Provider Additional Qualifications</b>	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
<b>2103.10</b>	<b>Residential Support Management</b>	<p>Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.</p> <p>Reworded to differentiate the service coordinator (ADSD) from residential support management which is an enrolled provider.</p>
<b>2103.11</b>	<b>Residential Habilitation - Direct Support Management Provider Responsibilities/Quali fications</b>	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
<b>2103.12</b>	<b>Non-Medical Transportation</b>	<p>Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.</p> <p>Removed reference to family, friends, and neighbors as only services needed must be prior authorized. Reference to MSM 1900 for State Plan Transportation was added.</p>
<b>2103.12B</b>	<b>Non-Medical Transportation Provider Responsibilities/Quali fications</b>	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
<b>2103.13</b>	<b>Nursing Services</b>	<p>Updated nursing services definition to match definition in the waiver application.</p> <p>Clarified that services must be provided in accordance with Nevada's nurse practice act.</p> <p>Clarified services to be provided under nursing services.</p> <p>Added reference to NRS 632 for licensed nurses.</p> <p>Removed references to participant direction.</p>

<b>2103.14</b>	<b>Nutrition Counseling Services</b>	<p>Added additional information to this service to provide clarity.</p> <p>Clarified monthly case notes, not quarterly.</p> <p>Added #7 which is the service requirements and limitation. In addition, added requirements if service limit is exceeded.</p>
<b>2103.14B</b>	<b>Nutrition Counseling Services Provider Additional Qualifications</b>	<p>In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.</p>
<b>2103.15</b>	<b>Career Planning</b>	<p>This entire section is new as it is a new waiver service.</p> <p>Language for this service matches what is outlined in the waiver to include provider qualifications.</p> <p>In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.</p>
<b>2103.16A.1</b>	<b>Slot Provision</b>	<p>Reworded section to provide clarity to case managers on how to assess potential recipients on how to assess potential recipients prior to placement on the wait list and the requirements necessary to be eligible for the wait list. It also discussed their requirement to request a Notice of Decision (NOD) from the DHCFP if an individual is not eligible for waiver services.</p> <p>Clarified reinstatement process for individuals who are admitted into long term care and may be released back into the waiver.</p> <p>Reworded this section to provide clarity to case managers on steps necessary to process new recipients who have been issued a waiver slot from the wait list.</p> <p>Clarified prioritization for waiver wait list and the allocation of waiver slots.</p> <p>Clarified intake processes once a waiver slot has been assigned.</p>
<b>2103.16A.2</b>	<b>Waiver Referral and Placement on the Wait List</b>	<p>Removed section that referenced self direction as this is currently not in the waiver.</p>

		Added statement regarding application for Medicaid benefits through the DWSS.
		Removed place of reassessment and changed direct to residential.
<b>2103.20A</b>	<b>Coverage and Limitations</b>	Reworded this entire section to include the CMS requirements for waiver reviews.
<b>2104.1</b>	<b>Suspended Waiver Services</b>	Removed section as NODS are no longer sent for suspended waiver services.
<b>2104.1</b>	<b>Denial of Waiver Services</b>	Added clarification of what imminent means.
<b>2104.2</b>	<b>Termination of Waiver Services</b>	Deleted reference to patient liability.
		Added reference for how to track individuals who are admitted to institutional placement, no jail, and how to track those cases in the event that someone is released timely and requests waiver services again.
<b>2104.3.j</b>	<b>Reduction or Denial Waiver Services</b>	Added service limits reason for reduction.
		Removed this statement as it is confusing for providers.
<b>2104.4A</b>	<b>Coverage and Limitations</b>	This is in addition to reference of how to track individuals who are placed in an institutional setting, not jail, and how to place them back on the waiver.
<b>2104.4B</b>	<b>Provider Responsibilities</b>	Clarified ADSD role when someone requests reinstatement within 90 days of being admitted to an institution as they have been discharged timely.
		Clarified ADSD's role in NOD's and timeframes.

# DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL TABLE OF CONTENTS

### HOME AND COMMUNITY BASED WAIVER

2100	INTRODUCTION .....	1
2101	AUTHORITY .....	1
2102	RESERVED .....	1
2103	POLICY .....	1
2103.1	WAIVER ELIGIBILITY CRITERIA.....	1
2103.1A	COVERAGE AND LIMITATIONS .....	1
2103.1B	MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) .....	4
2103.2	WAIVER SERVICES.....	4
2103.2A	PROVIDER RESPONSIBILITY.....	5
2103.2B	RECIPIENT RESPONSIBILITY .....	13
2103.3	SERVICE COORDINATION .....	14
2103.3A	COVERAGE AND LIMITATIONS .....	14
2103.4	DAY HABILITATION .....	14
2103.4A	COVERAGE AND LIMITATIONS .....	14
2103.4B	DAY HABILITATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS .....	15
2103.5	RESIDENTIAL SUPPORT SERVICES .....	15
2103.5A	COVERAGE AND LIMITATIONS .....	16
2103.6	RESIDENTIAL SUPPORT SERVICES PROVIDER RESPONSIBILITIES .....	18
2103.6A	PREVOCATIONAL SERVICES .....	19
2103.6B	COVERAGE AND LIMITATIONS .....	19
2103.6C	PREVOCATIONAL SERVICES PROVIDER RESPONSIBILITIES/QUALIFICATIONS.....	20
2103.7	SUPPORTED EMPLOYMENT .....	20
2103.7A	COVERAGE AND LIMITATIONS .....	21
2103.7B	SUPPORTED EMPLOYMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS .....	22
2103.8	BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION .....	23
2103.8A	COVERAGE AND LIMITATIONS .....	23
2103.8B	BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION PROVIDER RESPONSIBILITIES/QUALIFICATIONS .....	24
2103.9	COUSELING SERVICES .....	25
2103.9A	COVERAGE AND LIMITATIONS .....	25
2103.9B	COUNSELING SERVICES PROVIDER ADDITIONAL QUALIFICATIONS .....	26
2103.10	RESIDENTIAL SUPPORT MANAGEMENT .....	26
2103.10A	COVERAGE AND LIMITATIONS .....	27
2103.11	RESIDENTIAL HABILITATION - DIRECT SUPPORT MANAGEMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS .....	28
2103.12	NON-MEDICAL TRANSPORTATION.....	28
2103.12A	COVERAGE AND LIMITATIONS .....	29
2103.12B	NON-MEDICAL TRANSPORTATION PROVIDER	

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL  
TABLE OF CONTENTS

	RESPONSIBILITIES/ QUALIFICATIONS .....	29
2103.13	NURSING SERVICES .....	30
2103.13A	COVERAGE AND LIMITATIONS .....	31
2103.13B	NURSING SERVICES PROVIDER ADDITIONAL QUALIFICATIONS.....	32
2103.14	NUTRITION COUNSELING SERVICES .....	33
2103.14A	COVERAGE AND LIMITATIONS .....	33
2103.14B	NUTRITION COUNSELING SERVICES PROVIDER ADDITIONAL QUALIFICATIONS .....	33
2103.15	CAREER PLANNING .....	33
2103.15A	COVERAGE AND LIMITATIONS .....	34
2103.15B	CAREER PLANNING PROVIDER ADDITIONAL QUALIFICATIONS .....	34
2103.15C	PROVIDER ENROLLMENT PROCESS .....	35
2103.16	INTAKE PROCEDURES.....	35
2103.16A	COVERAGE AND LIMITATIONS .....	35
2103.17	BILLING PROCEDURES .....	38
2103.17A	COVERAGE AND LIMITATIONS .....	39
2103.18	PERMANENT CASE FILE .....	39
2103.19	SERVICE COORDINATOR RECIPIENT CONTACTS .....	39
2103.20	DHCFP ANNUAL REVIEW .....	40
2103.20A	COVERAGE AND LIMITATION.....	41
2103.20B	PROVIDER RESPONSIBILITIES .....	41
2104	HEARINGS .....	1
2104.1	DENIAL OF WAIVER APPLICATION .....	1
2104.2	TERMINATION OF WAIVER SERVICES.....	2
2104.3	REDUCTION OR DENIAL OF WAIVER SERVICES .....	3
2104.4	REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION .....	4
2104.4A	COVERAGE AND LIMITATIONS .....	4
2104.4B	PROVIDER RESPONSIBILITIES .....	4
2104.5	HEARINGS PROCEDURES .....	4

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2100
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

## 2100 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in Intermediate Care Facilities (ICFs) for Individuals with Intellectual Disabilities (IID) can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for Individuals with Intellectual Disabilities and Related Conditions originated in 1982. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium, the service needs and the funded slot needs of the waiver program are reviewed by the Aging and Disability Services Division (ADSD) and by the Division of Health Care Financing and Policy (DHCFP) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing individuals with an intellectual disability or a related condition with the opportunity to remain in a community setting in lieu of institutionalization. ADSD and the DHCFP understand that people who have intellectual disabilities or a related condition are able to lead satisfying and productive lives when they are provided the services and supports needed to do so. Both ADSD and the DHCFP are committed to the goals of self-sufficiency and independence.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2101
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

## 2101 AUTHORITY

Section 1915(c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of Home and Community-Based Services (HCBS) to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. The Division of Health Care Financing and Policy's (DHCFP's) Home and Community-Based Waiver (HCBW) for **Individuals with Intellectual Disabilities** and Related Conditions is approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

The DHCFP has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

### Statutes and Regulations:

- Social Security Act: 1915 (c)
- **Code of Federal Regulations (CFR)** (Title 42) Part 441, Subpart I (Community Supported Living Arrangements Services)
- CFR (Title 42) Part 483.430(a) (Qualified **Intellectual Disabilities** Professional (**QIDP**))
- **Nevada Revised Statute (NRS)** Chapter 435 (**Individuals with Intellectual Disabilities** and Related Conditions)
- Nevada Administrative Code (NAC) Chapter 435 (**Individuals with Intellectual Disabilities** and Related Conditions)

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2102
MEDICAID SERVICES MANUAL	Subject: RESERVED

2102          RESERVED

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

Nevada's Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions waives certain statutory requirements and offers Home and Community-Based Services (HCBS) to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with **intellectual disabilities** or a related condition and who have been found eligible and have an open case with an **Aging and Disability Services Division (ADSD)** Regional Center. Individuals are eligible if they meet Medicaid's eligibility requirements and are either in an Intermediate Care Facility for **Individuals with Intellectual Disabilities (ICF/IID)** or are at risk for ICF/IID placement without the provision of HCBS and supports.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver participants must meet and maintain Medicaid's eligibility requirements **through the Division of Welfare and Supportive Services (DWSS)** for all months waiver services are being provided.
2. The Home and Community-Based Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions is limited by legislative mandate and available matching state funding to a specific number of recipients who can be served through the waiver year. When all waiver slots are full, a wait list is utilized to prioritize applicants who have been presumed to be eligible for the waiver.
3. Wait List Prioritization
  - a. First priority is residents of an **ICF/IID**.
  - b. Second priority is applicants who are at risk of institutionalization due to loss of their current support system or crisis situation.
  - c. Third priority is applicants determined appropriate for waiver services.
4. The Division of Health Care Financing and Policy (DHCFP) must assure the Centers for Medicare and Medicaid Services (CMS) that Medicaid's total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100% of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. The DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

5. Waiver services must cease when an individual is admitted to a hospital or nursing facility for the duration of the stay. Residential settings that bill per diem may bill the per diem rate for admit and discharge days only when services were provided and documented for some part of the days in question. Residential settings that bill by the unit or hour may bill for services provided and documented on admit and discharge days.

6. The Waiver for Individuals with Intellectual Disabilities and Related Conditions Eligibility Criteria:

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Waiver for Individuals with Intellectual Disabilities and Related conditions.

a. Eligibility for the DHCFP's Waiver for Individuals with Intellectual Disabilities and Related Conditions is determined by the combined efforts of ADSD, the DHCFP and the DWSS. Two separate determinations must be made for eligibility for the Waiver:

1. Service eligibility for the waiver is determined by ADSD's regional office staff and authorized by the DHCFP's Central Office staff.

a. An ADSD Regional Center psychologist, based on supporting documentation, establishes the existence of an intellectual disability or a related condition.

b. Each applicant/recipient must meet and maintain Level of Care (LOC) for admission into an ICF/IID. The recipient would require imminent placement in an ICF/IID facility (within 30 to 60 days) if HCBW services or other supports were not available.

c. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an ICF/IID Utilization of State Plan Services solely does not support the qualifications to be covered by the waiver.

d. The applicant/recipient must have an adequate support system to provide a safe environment during the hours when HCBS are not being provided. HCBS are not a substitute for natural and informal supports provided by family, friends or other available community resources.

2. Eligibility determination for full Medicaid benefits is made by DWSS.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- a. Recipients of the Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions must be Medicaid eligible for full Medicaid benefits for all months in which waiver services are provided.
  - b. Services from the waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions cannot be provided until and unless the applicant is found eligible in both determination areas.
7. If an applicant/recipient is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant/recipient must choose one HCBW program and receive services provided by that program.
8. Recipients of the Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Collaborative case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.
9. An able and/or capable parent or Legally Responsible Individual (LRI) of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes but is not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family. Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems so the child is able to remain in their home. Allowance may be given in individual circumstances when there is no other LRI residing in the home and an able and/or capable parent's employment requirements result in prolonged or unexpected absences from the home, or when such employment requirements require the able and/or capable parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer, or when employment requirements include unconventional work weeks or work hours. **The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis. Without this verification, HCBW services will not be authorized.**
10. LRIs may not be reimbursed for HCBW services.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

11. Legal guardians of individuals age 18 and over are considered LRIs.

2103.1B MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions receive all the medically necessary Medicaid coverable service available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.2 WAIVER SERVICES

**ADSD**, the operating agency for the waiver, **in conjunction with the DHCFP and the state budget process**, determines which services will be offered under the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions. Providers and recipients must agree to comply with the requirements for service provision in accordance with **ADSD** and **the DHCFP** policies.

Under this waiver, the following services are **available** for individuals who have been **assessed** to be at risk for **ICF/IID** placement without the provision of enhanced supports as identified in the Individual Support Plan (ISP).

- a. Day Habilitation.
- b. Prevocational Services.
- c. Supported Employment.
- d. Behavioral Consultation, Training and Intervention.
- e. Residential Habilitation, **Residential Support Services**.
- f. Residential Habilitation, **Residential** Support Management.
- g. Counseling (Individual and Group).
- h. Non-Medical Transportation
- i. Nursing Services.
- j. Nutrition Counseling Services.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

k. Career Planning.

2103.2A PROVIDER RESPONSIBILITY

1. All Providers:

- a. Must enroll as a Provider Type 38 and maintain an active provider number.
- b. May not bill for services provided by a LRI.
- c. May only provide services that have been identified in the ISP.
- d. Must verify the Medicaid eligibility status of each HCBW recipient each month.
- e. Must be certified by Nevada Developmental Services pursuant to Nevada Revised Statute (NRS) 435 and Developmental Services Policy and Procedures.
- f. Meets all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100.
- g. Meets all conditions of participation in MSM Chapter 100, Section 102.
- h. Providers are required to present the following documents upon certification through ADSD and/or enrollment through the DHCFP's fiscal agent. Refer to Development Services Policy and Procedures, and the enrollment checklist located on the fiscal agent's website.

The minimum needed for enrollment through the DHCFP's fiscal agent:

1. Signed Statement or verification of Provider Certification from ADSD.
2. Signed Master Service Provider Agreement.

The following is part of ADSD's certification process:

3. Vendor Registration form.
4. Copy of business license(s) per city jurisdiction(s).
5. Copy of incorporation, LLC, Assumed/Fictitious Name or DBA (Doing business as) documents (if applicable).

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

6. Copy of Professional Liability insurance, if applicable:
  7. Copy of Fire Safety Certificate(s) (for each worksite), if applicable.
    - a. Occurrence with \$300,000 aggregate.
  8. The State of Nevada as additional insured.
    - a. Coverage for physical and sexual abuse and molestation unless a specific waiver is granted according to Risk Management and Developmental Services.
  9. Copy of Wage and Hour Certification(s) (for each worksite), if applicable.
  10. Non Profit Organizations must provide copy of Articles of Incorporation, list of Board of Directors and/or organizational chart, if applicable:
  11. Submit proof, from insurance agent, that applicable Liability Insurance (as required by State Risk Management) can be written before commencement of contracted services.
  12. Worker's Compensation Insurance for Employees *or* Affidavit of Rejection of Coverage.
  13. Coverage for Employee Dishonesty (Organizational Providers only).
  14. Auto insurance:
    - a. For all Agency Owned or Leased Vehicles (Organizational Providers).
    - b. For vehicle(s) to be used in transporting individuals (if applicable) (Individual Provider).
  15. General Liability Insurance with *minimum* coverage limits of:
    - a. Organizational Providers - \$1,000,000 per occurrence with \$2,000,000 aggregate.
    - b. Individual Providers - \$100,000 per occurrence.
- i. Must have approval from ADSD in order to be compensated for providing services

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

to recipients of the Waiver for Individuals with Intellectual Disabilities and Related Conditions.

j. Criminal Background Checks:

A criminal background check is required for all owners, administrators, and employees who provide direct care to recipients.

1. The DHCFP policy requires all owners, administrators, and employees who provide direct care have a fingerprint based criminal history submitted prior to service initiation, and every five years thereafter. Providers may contact the Nevada Department of Public Safety (DPS) and inquire about opening an account under the National Child Protection Act/Volunteer Children's Act (NCPA/VCA). The purpose of the NCPA/VCA is to complete a fingerprint based background check for individuals providing services to children, elderly and the disabled.

NOTE: Internet based background checks are not acceptable as they are not fingerprint based.

2. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results on file. Hiring and continued employment is at the sole discretion of the provider. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):
  - a. murder, voluntary manslaughter or mayhem;
  - b. assault with intent to kill or to commit sexual assault or mayhem;
  - c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
  - d. abuse or neglect of a child or contributory delinquency;
  - e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of Nevada Revised Statutes (NRS);

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- f. a violation of any provision of NRS 200.700 through 200.760;
- g. criminal neglect of a patient as defined in NRS 200.495;
- h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
- i. any felony involving the use of a firearm or other deadly weapon;
- j. abuse, neglect, exploitation or isolation of older persons;
- k. kidnapping, false imprisonment or involuntary servitude;
- l. any offense involving assault or battery, domestic or otherwise;
- m. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
- n. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or
- o. any other offense that may be inconsistent with the best interests of all recipients.

Refer to MSM Chapter 100 for additional information.

- 3. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An “undecided” result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.
  - a. Must have **Cardio Pulmonary Resuscitation (CPR)** and First Aid training within 90 days of hire **if providing direct service**.
  - b. Must complete required training within six months of beginning employment.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- c. Providers must maintain relevant documentation of services provided on one or more documents, including documents that may be created or maintained in electronic format. This documentation must be kept in a manner as to fully disclose the nature and extent of services delivered.

The documentation must include:

1. Type of service.
2. Date of service.
3. Name of individual receiving service.
4. Individual record number.
5. Name of provider.
6. Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider. For example, an attendance record must have daily initials and documentation of time in and time out.
7. Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.
8. Begin and end time of the delivered service.
9. Initials of the recipient. If the recipient is unable to provide initials due to a cognitive and/or physical limitation, this will be clearly documented in the Individual Support Plan (ISP).
10. Each provider must cooperate with ADSD and/or State or Federal reviews or inspections.
11. Report any recipient incidents or problems to ADSD on a timely basis.
12. All service providers other than ADSD must obtain and

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

maintain a service Provider contract with **ADSD** prior to providing services to a waiver recipient.

13. Prior authorization for waiver services is made through the written ISP and the service contracts (agreements) which reflect the ISP.

14. Serious Occurrences.

4. Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the **ADSD** service coordinator by telephone/fax within 24 hours of discovery. A completed Serious Occurrence report must be made within five working days and maintained **on file by the agency**.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

- a. Unplanned hospitalization **or ER visit**;
- b. **Injury or fall requiring medical intervention**;
- c. **Alleged physical, verbal, emotional, sexual abuse or sexual harassment**;
- d. **Assault, violence, or threat**;
- e. **Suicide threat or attempt**;
- f. **Criminal activity or legal involvement**;
- g. **Alleged theft or exploitation**;
- h. **Medication error per ADS policy**;
- i. Loss of contact with the recipient for three consecutive scheduled days;
- j. **Elopement of a resident living in a 24-hour setting**;
- k. **Death of the recipient during the provision of Waiver Services, or a significant caregiver (paid or unpaid), if applicable; or**

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

1. Other.

5. Notification of Suspected Abuse or Neglect

State law requires that **individuals** employed in certain capacities must make a report to **the appropriate** law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect **the abuse, neglect or exploitation of a minor child, vulnerable adult or older individual**. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age 60 and over, **Elder Protective Services within ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. For vulnerable adults, report of abuse, neglect, exploitation and social isolation are to be made to local law enforcement.**

- a. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.
- b. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, or neglect.
- c. Other Age Groups - For all other individuals or vulnerable **individuals** - (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who":
  - 1. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or
  - 2. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.

6. Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response and outcome of the incident.

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS WITH INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 11
-----------------	--	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

The Provider must investigate and respond in writing to all written complaints within **ten** calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the waiver service coordinator at the Regional Center.

**7. Health Insurance Portability and Accountability Act (HIPAA), Privacy, and Confidentiality**

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other **Protected Health Information (PHI)**.

**8. ADSD:**

An Interlocal Contract between **ADSD** and the DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of the HCBW for **Individuals** with **Intellectual Disabilities** and Related Conditions.

**9. Provider Agencies:**

a. **All employees must have a separate file** which includes background checks (**initially and every five years**), reference checks, Cardio Pulmonary Resuscitation (CPR)/First Aid **certification** (within 90 days of the beginning of employment **and ongoing**), and **documentation of** new employee orientation **and ongoing training**.

b. All providers are required to provide annual training to employees on recipient rights, confidentiality, abuse, neglect and exploitation, including definitions, signs, symptoms, and prevention as well as reporting requirements. Providers will also complete established training requirements of the specific Regional Centers.

**10. Exemptions from Training**

a. The agency, may exempt a prospective service provider from those parts of **the** required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

## 2103.2B RECIPIENT RESPONSIBILITIES

Applicants or recipients must meet and maintain all criteria to be eligible and to remain on the Waiver for Individuals with Intellectual Disabilities and Related Conditions.

The recipient or the recipient's authorized representative will:

1. Notify the provider(s) and service coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and service coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and service coordinator of changes in medical status, service needs, address, and location, or of changes of status of LRI(s)/authorized representative.
4. Treat all staff and providers appropriately.
5. Initial and/or sign the provider service documentation verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.
6. Notify the provider when scheduled visits cannot be kept or services are no longer required.
7. Notify the provider of missed visits by provider staff.
8. Notify the provider and ADSD Service Coordinator of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
9. If applicable, furnish the provider with a copy of their Advance Directives (AD).
10. Not request a provider to work more than the hours authorized in the ISP.
11. Not request a provider to provide service for a non-recipient, family, or household members.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

12. Not request a provider to perform services not included in the **ISP**.
13. Contact the service coordinator to request a change of provider.
14. Sign all required forms unless otherwise unable to perform this task due to intellectual and/or physical limitations.

### 2103.3 SERVICE COORDINATION

#### 2103.3A COVERAGE AND LIMITATIONS

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions.

Refer to **MSM Chapter 2500** for allowable activities under Targeted Case Management. Administrative waiver activities are not billable under Targeted Case Management.

### 2103.4 DAY HABILITATION

Day Habilitation Services are regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that include performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skill, building positive social behavior and interpersonal competence, greater independence and personal choice. Services furnished are identified in the individual's ISP.

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and support plans, such as physical, occupational, or speech therapy.

Day habilitation services may also be used to enable individuals to participate in hobbies, clubs and/or senior related activities in the community, specifically for those who choose not to work or are at advanced ages.

#### 2103.4A COVERAGE AND LIMITATIONS

Participants who receive day habilitation services and support may include two or more types of non-residential services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

Day habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purpose of producing goods or performing services).

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Improvement Act (IDEA) (20 U.S.C. 1401 et seq.).

#### 2103.4B DAY HABILITATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
  - a. An employee of an agency that provides habilitation services and has met the requirements for certification under NRS and Nevada Administrative Code (NAC) 435 and/or **ADSD** policy must provide documentation to the DHCFP to maintain approved provider status. **ADSD** verifies provider qualifications annually.
  - b. An employee of an agency must have a High School Diploma or equivalent; however this requirement may be waived with approval from **ADSD**.
2. Individual Providers:
  - a. Must meet the requirements for certification according to policy and provide required documentation to the DHCFP to maintain approved provider status. **ADSD** will verify qualification annually.
  - b. Must be at least 18 years of age.
  - c. Must have a High School Diploma or equivalent; however, this requirement may be waived with approval from **ADSD**.
  - d. Must have the ability to implement the recipient's ISP.
  - e. Must have the ability to communicate with and understand the recipient.

#### 2103.5 RESIDENTIAL SUPPORT **SERVICES**

Residential Support Services are designed to ensure the health and welfare of the individual, as well as the welfare of the community at large, through protective oversight and supervision activities and supports to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for individuals to successfully, safely, and responsibly reside in their community.

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS</b> WITH <b>INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 15
-----------------	---	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

Residential Support Services are provided throughout the course of normal ADL, as well as in specialized training opportunities outlined in the participant's ISP. These services are individually planned and coordinated, assuring the non-duplication of services with other State Plan Services.

Residential support services staff is trained and responsible for implementing Individual Habilitation Plans, goals, objectives, and service supports related to residential and community living. These supports include the facilitation of personal care services such as activities of daily living and instrumental activities of daily living. In addition, services include effective communication skills, community inclusion and the development of natural support networks, mobility training, survival and safety skills, support and teaching of interpersonal and relationship skills, making choices and problem solving skills, community living skills, social and leisure skills, money management skills, as well as support and skill training in health care needs, to include medication management. Residential support services emphasize positive behavior strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the individual and general public. Services also support exercising individual rights and protect against rights violations and infringements without due process.

Intermittent supported living services are services provided by an individual or organizational provider to individuals residing in their own homes not requiring one-on-one supervision and/or 24 hour care.

A host home is a supported living arrangement within an integrated community neighborhood which provides residential support services in a family living setting.

Twenty-four hour Supported Living Services are residential support services provided 24 hours per day by an organizational qualified provider. These services are delivered within non-provider owned homes in integrated community neighborhood settings. There are some provider owned homes located in the rural area due to resource limitations.

Residential support services cannot duplicate the scope and nature of State Plan Personal Care Services. Any ADL or IADL that is covered in the Individual Habilitation Plan, whether it is completed for them or the individual is completing the task with supervision as part of their training, cannot be covered under State Plan Personal Care Services.

## 2103.5A COVERAGE AND LIMITATIONS

1. Residential Support Services staff are trained and responsible for implementing ISPs, goals, objectives and service supports related to residential and community living.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

These **services** include:

- a. the participation in the development of the ISP.
  - b. adaptive skill development.
  - c. facilitation of **personal care and** ADLs.
  - d. facilitation of community inclusion.
  - e. facilitation of IADLs to include teaching community living skills; interpersonal and relationship skills; **building of natural support networks**; choice making skills; social and leisure skills; budgeting and money management skills.
  - f. providing assistance with medication administration **through ADSD staff certified in a Developmental Services (DS) approved Medication Program.**
  - g. **providing assistance with support and skill training in health care needs.**
  - h. **facilitation of mobility training, survival and safety skills.**
2. **Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent to 24 hour supported living arrangements, as determined by the ISP team. Residential support services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment, unless otherwise approved by the regional center director. These settings are fully integrated within community residential neighborhoods and are owned or leased in the service recipient's name or on the behalf of the recipient, with the exception of approved Host Home services. In 24 hour supported living arrangements, protective oversight hours must be shared with other recipients in the home unless clear documentation exists that shows a need for one-on-one supervision due to health and safety needs of the person supported and approved by the agency director or designee.**
  3. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of Supportive Living Arrangements (SLAs):
    - a. **Residential support services in a 24 hour setting are limited to four recipients unless otherwise authorized by the Regional Center Director. Host Home SLA's are limited to two service recipients residing in one home, unless otherwise authorized by the DS Regional Center Director.**

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be approved and certified by **ADSD** in order to render services to **individuals** with **intellectual disabilities** and related conditions.

## 2103.6 RESIDENTIAL SUPPORT SERVICES PROVIDER RESPONSIBILITIES

### A. Individual Providers – Provider Managed:

1. Must be at least 18 years of age.
2. Must have a High School Diploma or equivalent (may be waived with **ADSD** approval).
3. Must have First Aid and CPR training within 90 days of hire.
4. Must have the ability to implement the recipient's ISP and Habilitation Plan.
5. Must have the ability to communicate with and understand the recipient.
6. Provider qualifications will be reviewed by **ADSD** on initial application, within the first year as part of certification review and at least every two years thereafter as part of re-certification review.

### B. Individual Providers – Participant-Directed:

1. Must be at least 18 years of age.
2. Must have the ability to communicate with and understand the participant.
3. Must provide three reference checks in accordance with **ADSD** policy.
4. Must have First Aid and CPR training within 90 days of hire.
5. Must meet the requirements specified in NAC 435 and provide information to the DHCFP to maintain approved provider status.
6. Must have the ability to implement the goals and services as identified in the participant's ISP.
7. Must have the ability to communicate with and understand the recipient.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

**C. Agency Providers – Provider Managed:**

1. Individuals providing direct services and support services must be at least 18 years of age.
2. Must have a High School Diploma or equivalent. This requirement may be waived with **ADSD** approval.
3. Must meet all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.
4. **ADSD** will verify provider qualification on initial application and provisional certification, within the first year as part of the Quality Assurance (QA) review for certification and at least every three years thereafter as part of the re-certification QA review.

**2103.6A PREVOCATIONAL SERVICES**

Prevocational Services are designed to create a path to integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be optimal outcomes for prevocational services. Individuals receiving prevocational services must have employment-related goals in their person-centered ISP; the general habilitative activities must be designed to support such employment goals.

Services include teaching such concepts as attendance, task completion, problem solving, interpersonal relations and safety, and communication with customers, co-workers, or supervisors. This service provides for learning and work experience, including volunteer work, participation in social and recreational activities to facilitate community integration, classroom style program/training, experience – where an individual can develop general, non-job or task specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the individual's ISP.

**2103.6B COVERAGE AND LIMITATIONS**

The prevocational services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the IDEA (20 U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each individual receiving prevocational services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS WITH INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 19
-----------------	--	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

1. Participants who receive prevocational services may include two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

## 2103.6C PREVOCATIONAL SERVICES PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
  - a. All provider agencies/organizations providing day habilitation services must meet the requirements for Certificate of Qualification in accordance with NRS 435.230 to 435.320, all inclusive or meet **ADSD** rules, regulation and standards and demonstrate a community need.
  - b. An employee of an agency must have a High School Diploma or equivalent, however, this requirement may be waived with approval from **ADSD**.
  - c. Annual certification is required for certified centers meeting requirements under NRS and NAC 435.
  - d. All providers must meet all requirements to enroll and maintain Medicaid provider status according to MSM Chapters 100 and 2100, as applicable.
  - e. Must meet all conditions of participation according to MSM Chapter 100, Section 102.1.

## 2103.7 SUPPORTED EMPLOYMENT

Supported employment service is a combination of intensive ongoing supports and services that prepare recipients for paid employment.

Supported employment services are individualized and may include any combination of the following services: Vocational job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefit supports, training and planning, transportation (by the employment provider to any sub-sites or necessary to complete the job), asset development and career advancement services and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Individual employment supports are services for individuals who, because of their disabilities, need intensive ongoing supports to obtain and maintain an individual job in competitive employment or customized employment, or self-employment, in an integrated work setting in the

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS</b> WITH <b>INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 20
-----------------	---	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Customized employment is another approach to supported employment. Customized employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interest of the person with disabilities, and is also designed to meet the specific needs of the employer. Customized employment assumes the provision of reasonable accommodations and support necessary to perform the function of a job that is individually negotiated and developed.

Supported employment small group employment supports may include any combination of the following services: vocational/job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit supports, training and planning, transportation and career advancement services. Other workplace supports may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating in the job setting.

The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level benefits paid by the employer of the same or similar work performed by individuals without disabilities. Small group employment does not include vocational services provided in a facility based work setting.

#### 2103.7A COVERAGE AND LIMITATIONS

1. When supported employment services are provided at a work site in which individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.
2. Supported employment may be furnished as expanded habilitation services under the provision of the 1915 (c) of the Act. It is important to note that such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973 or, in the case of youth, under the provision of the Individuals with Disabilities Educational Act (IDEA).

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

3. Supported employment small group employment support are services and training activities provided in regular business, industry and community settings of two to eight workers with disabilities. Examples include mobile crews and other business-based work groups employing a small group of workers with disabilities in employment in the community. Supported employment small group work employment supports must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
4. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
  - b. Payments that are passed through to users of supported employment programs; or
  - c. Payments for vocational training that is not directly related to an individual's supported employment program.

#### 2103.7B SUPPORTED EMPLOYMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
  - a. Employees of an agency that provides supported employment services must meet the requirements for certification in accordance with NRS 435 and **ADSD** policy, and provide required documentation to the DHCFP to maintain approved provider status
  - b. Must be at least 18 years of age.
  - c. Must have a High School Diploma or equivalent; however, this may be waived with approval of **ADSD**.
  - d. Must meet all requirements to enroll and maintain enrolled Medicaid provider pursuant to the DHCFP MSM, Chapter 100 and 2100.
2. Individual Providers – Provider Managed:
  - a. Must have a High School Diploma or equivalent; however, this may be waived with approval of **ADSD**.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. Must have the ability to implement the recipient's ISP.
  - c. Must have the ability to communicate with and understand the recipient **ADSD** will verify provider qualification on initial application and annually thereafter.
- 3. Individual Providers – Participant-Directed:
  - a. Must be at least 18 years of age.
  - b. Must have the ability to communicate with and understand the participant.
  - c. Must provide three reference checks in accordance with **ADSD** policy.
  - d. Must have First Aid and CPR training within 90 days of hire.
  - e. Must meet the requirements specified in NAC 435 and provide information to the DHCFP to maintain approved provider status.
  - f. Must have the ability to implement the goals and services as identified in the participant's ISP.
  - g. Must have the ability to communicate with and understand the recipient.

## 2103.8 BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION

Behavioral consultation, training and intervention services **provide behaviorally-based assessment and intervention for participants, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of Individual Support Plans and/or positive behavior support plans, necessary to improve an individual's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. These services are not covered under the State Plan and are provided by professionals in psychology, behavior analysis and related fields.**

## 2103.8A COVERAGE AND LIMITATIONS

- 1. Behavioral consultation, training and intervention may be provided in the recipient's home, school, workplace, and in the community. The services include:
  - a. **functional behavioral assessment and an** assessment of the environmental factors that are precipitating a problem behavior.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. development of behavior support plan in coordination with the team members.
- c. consultation or training on how to implement positive behavior support strategies and/or behavior support plan.
- d. consultation or training on data collection strategies to monitor progress.
- e. monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary.

Behavioral Consultation, Training and Intervention may not exceed \$5,200.00 per year.

#### 2103.8B BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

##### 1. In addition to the provider qualification listed in this chapter:

- a. Employees of behavioral provider agencies must have provisional or regular certification per NRS 435 and have a Bachelor's degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied setting; or
- b. Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.
- c. Experience working with individuals with intellectual disabilities or related conditions is preferred.
- d. Must meet all requirements to enroll and maintain status as Medicaid provider pursuant to the DHCFP MSM, Chapters 100 and 2100, as applicable.

##### 2. Individual Providers:

- a. Bachelors degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied settings; or

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. Master's degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports.
- c. Experience working with individuals with intellectual disabilities or related conditions is preferred.
- d. Must have criminal clearance in accordance with the DHCFP and **ADSD** policy.
- e. **ADSD** will verify qualifications prior to approval of initial provider agreement and annually thereafter.

## 2103.9 COUNSELING SERVICES

Counseling services provide assessment/evaluation, consultation, therapeutic interventions, support and guidance for waiver participants and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the individual's personal adaptation and inclusion in the community. This service is available to individuals who have intellectual and/or developmental disabilities and provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the participant's ISP.

Counseling services are specialized and adapted in order to accommodate the unique complexities of enrolled participants and include consultation with team members, including family members, support staff, service coordinators and other professionals comprising the participant's support team; individual and group counseling services; assessment/evaluation services; therapeutic interventions strategies; risk assessment; skill development; and psycho educational activities.

Counseling services are provided based on the participant's need to assure his or her health and welfare in the community and enhance success in community living.

## 2103.9A COVERAGE AND LIMITATIONS

Counseling services may include:

- 1. individual and group counseling services;
- 2. assessment/evaluation services;
- 3. therapeutic intervention strategies;

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

4. risk assessment;
5. skill development; and
6. psycho-educational activities.

Counseling services may not exceed \$1,500.00 per year.

#### 2103.9B COUNSELING SERVICES PROVIDER ADDITIONAL QUALIFICATIONS

1. In addition to the provider qualifications listed in this chapter:
  - a. Providers under this category must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field. A closely allied field is licensed by the state by appropriate categories. A graduate level intern supervised by a licensed clinician or mental health counselor may provide these services; or
  - b. A graduate level intern who is enrolled in a Master's level program at an accredited college or university that provides at least two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field or doctor level program in a clinical field; and
  - c. Are supervised by a licensed clinician or mental health counselor (professional experience in a setting servicing individuals with intellectual disabilities is preferred).
  - d. Professional experience in a setting serving individuals with intellectual disabilities is preferred.
  - e. ADSD will verify provider qualifications upon enrollment and prior to expiration of the license; the provider will send a copy of the current license to the ADSD.

#### 2103.10 RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of individuals receiving residential support services from agencies in order to assure those services and supports are planned, scheduled, implemented and monitored as the individual prefers and needs depending on the frequency and duration of approved services. Residential support managers assist the participant with managing their residential supports.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

Residential support managers must work collaboratively with the participant's Targeted Case Manager. Residential Support Management services are different from Targeted Case Management. The Targeted Case manager is responsible for the development of the ISP, which is the overall HCBS plan, in consultation with the ISP team.

The Residential Support Manager is responsible to develop, implement, and monitor the specific residential habilitation plan related to Residential Support Services.

#### 2103.10A COVERAGE AND LIMITATIONS

1. **Residential** Support Management staff will assist the recipient in managing their supports within the home and community settings. This service includes:
  - a. assisting the person to develop his or her goals;
  - b. scheduling and attending **Individual Support Team Planning** meetings;
  - c. **develop habilitation plans specific to residential support services, as determined in the participant's ISP and train residential support staff in implementation and data collection;**
  - d. assisting the **individual** to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Food Stamps, housing, etc.;
  - e. assisting the **individual** in locating residences;
  - f. assisting the **individual** in arranging for and effectively managing generic community resources and informal supports;
  - g. assisting the **individual** to identify and sustain a personal support network of family, friends, and associates;
  - h. providing problem solving and support with crisis management;
  - i. supporting the **individual** with budgeting, bill paying, and with scheduling and keeping appointments;
  - j. observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the ISP;

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- k. following up with health and welfare concerns and remediation of deficiencies;
- l. completing required paperwork on behalf of the recipient (as needed);
- m. making home visits to observe the **individual's** living environment to assure health and welfare; and
- n. providing information to the Service Coordinator (Targeted Case Manager) to allow evaluation and assurance that support services provided are those defined in the ISP and are effective in assisting the recipient to reach his or her goals.

#### 2103.11 RESIDENTIAL HABILITATION – DIRECT SUPPORT MANAGEMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

##### **A.** Agency Providers:

- 1. Employees of an agency that provides direct support management services must be at least 18 years of age;
- 2. Must be certified (including provisional certification according to NAC 435) and provide required information to DHCFP to maintain approved provider status;
- 3. Must have a High School Diploma or equivalent and two years experience providing direct service in a human services field and under the direct supervision/oversight of a Qualified **Intellectual Disabilities** Professional (QIDP) or its equivalent;
- 4. Completion of Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely allied field;
- 5. Meet all requirements to enroll and maintain status as an enrolled provider pursuant to the DHCFP MSM Chapters 100 and 2100, as applicable; or
- 6. **ADSD** will verify Direct Service and Support staff qualification upon application for enrollment for provisional certification and within the first year of enrollment as part of initial Quality Assurance certification review. Verification will occur at least every two years thereafter as part of re-certification review.

#### 2103.12 NON-MEDICAL TRANSPORTATION

**Non-medical transportation service is offered to enable waiver recipients to gain access to community activities and services that are identified in the recipients ISP. Non-medical**

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS</b> WITH <b>INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 28
-----------------	---	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

transportation service allows individuals to engage in normal day-to-day non-medical activities such as going to the grocery store or bank, participating in social events or attending a worship service. Whenever possible, family, neighbors, friends, or community agencies should provide this service without charge.

#### 2103.12A COVERAGE AND LIMITATIONS

1. This service will not duplicate or impact the amount, duration and scope of the medical transportation benefit provided under the Medicaid State Plan. Refer to MSM Chapter 1900 for more information regarding the coverage and limitations of medical transportation.
2. Non-medical transportation services under this waiver must be described or identified in the recipient's ISP and pre-authorized before the service is utilized.

#### 2103.12B NON-MEDICAL TRANSPORTATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Individual Providers:
  - a. Must have a valid Nevada Driver's License and provide proof of liability insurance.
  - b. Must show evidence of vehicle safety inspection prior to hire and are subject to periodic vehicle safety inspections. Providers are responsible for obtaining safety inspections and providing them to ADSD upon request.
  - c. Must be at least 18 years of age.
  - d. Must have a high school diploma or equivalent.
  - e. Must have at least six months of specialized training and experience in working with individuals with disabilities in a community setting.
  - f. Must have the ability to communicate with and understand the participant.
  - g. Must provide three reference checks in accordance with ADSD policy.
  - h. Must have First Aid and CPR training within 90 days of hire.
  - i. Must meet the requirements specified in NAC 435 and provide information to DHCFP to maintain approved provider status.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- j. Must have the ability to implement the goals and services as identified in the participant's ISP.

2. Agency Provider – Provider Managed:

- a. An employee of an agency must have a valid Nevada Driver's License.

An agency must have uninterrupted liability insurance per Nevada State Risk Management specification and **ADSD** policy; automobile insurance, per State of Nevada requirements including all automobiles owned and leased by the agency; and assurance of routine vehicle safety and maintenance inspection on file.

- b. An employee of an agency that provides direct support services must be certified (including provisional certification) in accordance with NAC 435 as a Supported Living Provider.
- c. Must meet all requirements to be enrolled and maintain status of an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.
- d. Must meet all conditions of participation in MSM Chapter 100, Section 102.1.
- e. **ADSD** will verify provider qualification prior to approval of initial provider agreement and annually thereafter.

2103.13 NURSING SERVICES

There are three components of this service: Direct Services, Comprehensive Medical Community Support Services, and Nursing Assessment.

Direct Services: Direct skilled nursing services are intended to be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in a community setting as described and approved in the recipient's ISP. LPN's must be under the supervision of an RN licensed in the state. Services include skilled medical care that is integral to meeting the daily medical needs of the recipient. These services are intended to allow individuals under this waiver to live safely within an integrated community setting. Services are limited to those that only a licensed professional can provide; not those that unlicensed staff can provide. For example, ADL's are not skilled services. Skilled services include, but are not limited to: medication administration, wound care, nasogastric or gastrostomy tube feeding, ostomy care, tracheotomy aspiration care, and catheter care. Direct services will be reimbursed when the procedure can be only be performed safely by a RN or LPN. Factors to consider when determining the need for direct nursing services include: the complexity of the procedure; the recipient's functional and physical

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS</b> WITH <b>INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2103 Page 30
-----------------	---	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

status; the absence of a caregiver who is trained to perform the function; and that the service is reasonable and necessary.

**Comprehensive Medical Community Support Services:** These services will be provided by an RN or LPN under the supervision of an RN licensed in the state. Services are geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. This service includes professional observation and assessment, individualized program design and implementation, training of recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that this service relates directly to the medical needs of the individual. In addition, nurses may attend ISP team meetings and physician visits as needed to provide advocacy, resource information and recommendations to team and treating physicians in order to facilitate health supports.

**Nursing Assessment:** Assessments are completed by an RN and provide the basis for recommendations for medical and mental health care and follow-up; which are shared with the person's team for review and inclusion in the individual's support plan. The assessment includes: an interview with the recipient; identification of diagnoses, including symptoms and signs of condition; assessment of verbal and nonverbal communication skills; a review of medical and social history including current medication and drug history; as well as other information available from either records or interviews with staff and family. The RN will assess vital signs, skin color and condition, motor and sensory nerve function, nutrition, sleep patterns, oral health, physical activities, elimination, and consciousness. Additionally, an assessment of the recipient's social and emotional factors and status will be completed to include; religion, thoughts on health care, mood, and social/support networks.

#### 2103.13A COVERAGE AND LIMITATIONS

1. Routine nursing services are services within the Scope of the Nevada Nurse Practice Act.
2. Services must be provided by an RN or Licensed Practical Nurse (LPN) under the supervision of an RN who is licensed to practice as a nurse in the State of Nevada.
3. Nursing Services may include:
  - a. Medication administration.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. Assessments (including nursing assessment).
  - c. Development of treatment plan or support plan.
  - d. Training and technical assistance for paid support staff to carry out treatment plan or support plan.
  - e. Monitoring of the recipient and the provider in the implementation of the plan and **provide nursing case notes of the services provided and the outcomes of those services.**
  - f. Referrals to **home** health care or other medical providers for certain treatment procedures covered under the Medicaid State Plan.
- 4. Nursing services may be provided in the recipient's home, day program, or in other community settings as described in the Service Plan.
  - 5. Medical and health care services such as physician services that are not routinely required to meet the daily needs of waiver recipients are not covered under this service. Nursing services provided in this waiver will not duplicate the nursing services covered under the Medicaid State Plan.

#### 2103.13B NURSING SERVICES PROVIDER **ADDITIONAL** QUALIFICATIONS

- 1. Individual Provider and Provider Managed – Level 1:
  - a. **Must be an** RN in accordance with NRS 632 licensing requirements.
  - b. **May be an** LPN under the supervision of an RN in accordance with NRS 632 licensing requirement.
  - c. **ADSD will verify provider qualifications upon enrollment and annually thereafter. Providers are required to send a copy of the current license to ADSD.**
- 2. Agency Providers:
  - a. Employees of a Home Health Agency (HHA), Nursing Registry, or private service providers must be an RN in accordance with NRS 632.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

#### 2103.14 NUTRITION COUNSELING SERVICES

Nutrition counseling services include assessment of the **individual's** nutritional needs, development and/or revision of recipient's nutritional plan, counseling and nutritional intervention, observation and technical assistance related to successful implementation of the nutritional plan.

**These waiver-covered dietitian duties are above and beyond those approved and covered under State Plan Services**

#### 2103.14A COVERAGE AND LIMITATIONS

1. Training, education and consultation for recipients and their families or support staff involved in the day-to-day support of the recipient.
2. Comprehensive assessment of nutritional needs.
3. Development, implementation and monitoring of nutritional plan incorporated in the ISP, including updating and making changes in the ISP as needed.
4. Assist in menu planning and healthy menu options.
5. Provide nutritional education and consultation.
6. Provide **monthly case notes on nutritional activities and** summaries of progress on the nutritional plan.

**This service requires a physician's order, determination of medical necessity, and the individual's health must be at risk. This service is limited to \$1,300.00 per year, per individual. This service does not include the cost of meals or food items.**

#### 2103.14B NUTRITION COUNSELING SERVICES PROVIDER **ADDITIONAL** QUALIFICATIONS

1. **In addition to the provider qualifications listed in this chapter, providers must be:**
  - a. **a registered Dietician as certified by the American Dietetic Association.**
  - b. **licensed to practice in the state of Nevada.**

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

## 2103.15 CAREER PLANNING

Career planning is a person-centered, comprehensive employment planning and support services that provide assistance for waiver recipients to obtain, maintain, or advance in competitive employment or self employment. This service will engage waiver recipients in indentifying a career direction and developing a plan for achieving integrated employment at or above minimum wage.

The outcome of this service is documentation of the individual's stated career objective and career plan used to guide individual employment support. Services include planning for sufficient time and experiential learning opportunities to allow for appropriate exploration, assessment and discovery processes for learning about career options, as well as the participant's skills and interests. Career planning may include informational interviewing, job tours, job shadowing, community exploration, community and business research, benefit supports, job preference inventories, situational and community-based assessments, job sampling, training and planning, as well as assessments for the use of assistive technology in the workplace to increase independence.

### 2103.15A COVERAGE AND LIMITATIONS

The ISP may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed simultaneously. If a waiver participant is receiving pre-vocational services or day habilitation services, career planning may be used to develop additional learning opportunities and career options consistent with the person's skills and interest. Career Planning will be limited to 40 days and a specified number of hours identified in the ISP.

### 2103.15B CAREER PLANNING PROVIDER ADDITIONAL QUALIFICATIONS

In addition to the provider qualifications listed in this chapter, providers of Career Planning must have:

1. Education and experience equivalent to a Bachelor's degree in social services, rehabilitation, or business. Experience in working with individuals with intellectual disabilities and related conditions providing employment service and job development. Must demonstrate knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.
2. Valid Nevada driver's license required. Must have access to an operational and insured vehicle and be willing to use it to transport individuals. (Providers will bill Career Planning unit rate for time spent transporting, not a separate rate).

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

3. Individual must make a commitment to becoming a certified Employment Specialist through enrollment in national recognized employment courses.
4. Must have the ability to communicate with and understand the recipient.

#### 2103.15C PROVIDER ENROLLMENT PROCESS

1. All providers should refer to the MSM Chapter 100 for enrollment procedures.
2. All providers must comply with all the DHCFP and **ADSD** enrollment requirements, provider responsibilities/qualifications, and the DHCFP and **ADSD** provider agreement and limitations set forth in this chapter.
3. Provider non-compliance with all or any of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

#### 2103.16 INTAKE PROCEDURES

The **ADSD** has developed policies and procedures to ensure fair and adequate access to the HCBW for **Individuals** with **Intellectual Disabilities** and **Related** Conditions.

#### 2103.16A COVERAGE AND LIMITATIONS

##### 1. SLOT PROVISION

- a. The allocation of waiver slots is maintained at the **ADSD** Regional Offices. As waiver slots become available, **ADSD** determines how many slots may be allocated.
- b. **Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements, or request termination, and send a Notice of Decision (NOD). Their slot may be given to the next person on the wait list. If they request waiver services at a later date, they are placed on the bottom of the list by category with a new referral date.**
- c. **When a recipient is placed in a nursing facility, ICF/IID, or hospital, they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date, and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the wait list. If a recipient requests reinstatement after the 90 days is over, they are treated as a new referral.**

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

## 2. WAIVER REFERRAL AND PLACEMENT ON THE WAIT LIST

a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local ADSD Regional Office. Regional center staff will discuss waiver services, including eligibility requirements with the referring party or potential applicant.

b. The service coordinator must conduct a Level of Care (LOC) screening to verify eligibility for the wait list.

NOTE: If the applicant does not meet an LOC, they will receive a NOD which includes the right to a fair hearing.

c. All applicants who meet program criteria must be placed on the statewide waiver wait list by priority and referral date. The following must be completed before placement on the wait list:

1. The applicant must meet LOC criteria for placement in an ICF/IID.
2. The applicant must require at least one ongoing waiver service.
3. The applicant must meet criteria for IID or a Related Condition.

Applicants must be sent a NOD indicating “no slot available”. ADSD will notify the DHCFP Central Office Waiver Unit via NMO-2734 when no slot is available. The applicant will remain on the waiting list.

## 3. WAIVER SLOT ALLOCATION

Once a slot is allocated, the applicant will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

a. The ADSD service coordinator will schedule a face-to-face visit with the recipient to complete the full waiver assessment to include diagnostic data, LOC determination, and will obtain all applicable forms, including the Authorization for Release of Information.

The applicant and/or an authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

The **ADSD** service coordinator will inform the applicant and/or an authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information without a signed **authorization** for **release of information**.

The service coordinator will provide an application to apply for Medicaid benefits through DWSS. The recipient is responsible for completing the application and submitting all requested information to DWSS. The case manager will assist upon request.

- b. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an ICF/**IID**. If the applicant and/or legal representative prefers placement in an ICF/**IID**, the service coordinator will assist the applicant in arranging for facility placement.
- c. The applicant/recipient will be given the right to request a hearing if not given a choice between HCBS and ICF/**IID** placement.
- d. When the applicant/recipient is approved by **ADSD** for waiver services, the following will occur:
  1. A team meeting is held and a written **ISP** is developed in conjunction with the recipient and the Individual Support Team to determine specific service needs **and** to ensure the health and welfare of the recipient.
  2. The recipient, the recipient's family, or the legal representative/authorized representative **are included** in the development of the **ISP**.
  3. The **ISP** is subject to the approval of the **Central Office** Waiver Unit of the DHCFP.
  4. Recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in his/her written individual support plan. Current **ISPs** must be given to all service providers and kept in the participant's record.
  5. All forms must be complete with signature and dates where required.
  6. **ADSD** will forward a completed waiver **packet** and **form NMO-2734** requesting **waiver** approval to the DHCFP **Central Office** Waiver Unit.
    - a. If the **waiver packet** is not approved the following will occur:

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

1. A NOD stating the reason(s) for the denial will be sent to the applicant, the ADSD service coordinator, and DWSS by the DHCFP Central Office Waiver Unit via the Hearings and Policy Unit.

b. If the waiver packet is approved the following will occur:

1. Form NMO-2734 will be sent by the DHCFP Central Office Waiver Unit to the ADSD service coordinator. ADSD is responsible for notifying DWSS of approval to coordinate slot allocation with DWSS approval.
2. Once the waiver has been approved by DWSS, waiver services can be initiated.

#### 4. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

In some cases, it may be necessary to begin waiver services on the 1<sup>st</sup> of the month to coincide with Service Contracts. In that case, the effective date for waiver services approval is the completion date of all the intake forms or the first of the month the waiver eligibility determination is made by DWSS, whichever is later.

Waiver services will not be backdated beyond the first of the month in which the waiver eligibility determination is made by DWSS.

#### 5. WAIVER COST

The DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional LOC under the state plan that would have been made in that fiscal year, had the waiver not been granted.

#### 2103.17 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible and only when the service is included in the approved individual support plan.

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES AND RELATED CONDITIONS	Section 2103 Page 38
-----------------	--	----------------------

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

#### 2103.17A COVERAGE AND LIMITATIONS

**ADSD** (Provider Type 38) must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate provider claims will be returned to **ADSD** by the DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to **ADSD** by the DHCFP's fiscal agent.

#### 2103.18 PERMANENT CASE FILE

- A. For each approved waiver recipient, the service coordinator must maintain a permanent case file that documents services provided under the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions.
- B. These records must be retained for six years from the date of waiver service(s).

#### 2103.19 SERVICE COORDINATOR RECIPIENT CONTACTS

- A. **Contacts**
  1. The service coordinator must have **ongoing** contact with each waiver recipient, a recipient's **personal** representative, or the recipient's direct care service provider, **by any means chosen by the recipient or representative. The contact must be sufficient to address health and safety needs of the recipient, and at a minimum, there must be a face-to-face visit with each recipient annually.**
  2. **During ongoing contact, the service coordinator will monitor the person's current condition to include health and safety, assess for changes needed, satisfaction with services and supports, whether the habilitation plans are meeting identified goals, and provide any necessary follow up on needs or concerns.**
- B. **Reassessment**
  1. Recipients must be reassessed annually.
  2. The recipient must be reassessed when there is a significant change in his/her condition.
  3. **Scope, frequency, and duration must be identified on the ISP, with the exception of Residential Support Management. Providers cannot exceed the maximum allowed as indicated on the ISP.**

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

4. When the recipient service needs increase, due to a temporary condition or circumstance, the service coordinator must thoroughly document the increased service needs in their case notes. The ISP does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.
5. **Residential** support management hours are defined in the ISP. A temporary increase in the **residential** support management hours for the participant must receive prior authorization from **ADSD** and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a 30 day period, there must be a re-assessment based on thorough documentation in the **residential** support managers case notes reflecting the health, safety and welfare concerns and the ISP must be revised.

a. Reassessment Procedures

During the reassessment process, the service coordinator should:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1A.6 of MSM Chapter 2100.
2. Re-assess the recipient's ability to perform ADLs, his/her medical and mental status and support systems.
3. Re-evaluate the services being provided and progress made toward the goal(s) stated on the individual support plan.
4. Develop a new individual support plan and review the waiver costs.
5. Re-assess the recipient's LOC.

2103.20 DHCFP ANNUAL REVIEW

The State will have in place a formal system by which it assures the health and welfare of the recipients served on the waiver, the recipient's satisfaction with the services and the cost effectiveness of these services.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2103
MEDICAID SERVICES MANUAL	Subject: POLICY

#### 2103.20A COVERAGE AND LIMITATIONS

The DHCFP (administrative authority) and **ADSD** (operating agency) will collaboratively conduct an annual review of the waiver program to assess quality of life, functional independence, and health and welfare of recipients receiving waiver services. The State must operate this waiver in accordance with certain “assurances” identified in Federal regulations. CMS has designated six waiver assurances that states must include as part of an overall quality improvement strategy, which are:

1. **Level of Care:** Recipients enrolled meet level of care criteria consistent with individuals residing in institutional settings.
2. **Service Plan:** A recipient’s needs and preferences are assessed and reflected in a person centered service plan.
3. **Qualified Providers:** Provider agencies and workers providing services are qualified either through licensure or certification.
4. **Health and Welfare:** Recipients are protected from abuse, neglect and exploitation and receive supports to address identified needs.
5. **Financial Accountability:** Verification that reimbursement is only made for services that are approved and provided, and the cost of those services does not exceed the cost of institutional care on a per person or aggregate basis (as determined by the state).
6. **Administrative Authority:** The DHCFP is fully accountable for HCBS waiver design, operations and performance.

#### 2103.20B PROVIDER RESPONSIBILITIES

Providers must cooperate with the DHCFP’s annual review process.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2104
MEDICAID SERVICES MANUAL	Subject: HEARINGS

2104 HEARINGS

2104.1 DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

- a. The applicant does not meet the criteria of being diagnosed with **intellectual disability** or having a condition related to **an intellectual disability**.
- b. The applicant does not meet the Level of Care (LOC) criteria for placement in an **Intermediate Care Facility (ICF)/ Individuals with Intellectual Disabilities (IID)**.
- c. The applicant has withdrawn their request for waiver services.
- d. The applicant fails to cooperate with the service coordinator or the **Home and Community-Based Services (HCBS)** providers in establishing and/or implementing the **Individual Support Plan (ISP)**, implementing waiver services, or verifying eligibility for waiver services.
- e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. **HCBS** services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The agency has lost contact with the applicant.
- g. The applicant fails to show a need for **Home and Community-Based Waiver** services.
- h. The applicant would not require imminent placement in an ICF/**IID** if HCBS were not available. (**Imminent placement means within 30 to 60 days.**)
- i. The applicant has moved out of state.
- j. Another agency or program will provide the services.
- k. **ADSD** has filled the number of slots allocated to the HCBW for **Individuals with Intellectual Disabilities** and Related Conditions. The applicant has been approved for the waiver waiting list and will be contacted when a slot is available.

When the application for waiver services is denied the service coordinator will send a notification (Form NMO-2734) to the DHCFP **Central Office** Waiver Unit identifying the reason for denial. The Waiver Unit will send a **Notice of Decision (NOD)** for Payment Authorization

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS WITH INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2104 Page 1
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	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2104
MEDICAID SERVICES MANUAL	Subject: HEARINGS

Request (Form NMO-3582) to the applicant or the applicant's **personal** representative. The service coordinator will submit the form within **five** days of the date of denial of waiver services.

## 2104.2 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

- a. The recipient no longer meets the criteria of **an intellectual disability** or having a related condition.
- b. The recipient no longer meets the **LOC** criteria for placement in an ICF/**IID**.
- c. The recipient has requested termination of waiver services.
- d. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- e. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. Home and Community-Based services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The recipient fails to show a continued need for HCBW services.
- g. The recipient no longer requires imminent ICF/**IID** placement if HCBS were not available. (Imminent placement means within 30 to 60 days.)
- h. The recipient has moved out of state.
- i. Another agency or program will provide the services.
- j. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, **ICF/IID**, or incarcerated). **\*\*\*\*See below.**
- k. **ADSD** has lost contact with the recipient.
- l. The recipient has not utilized any waiver services over a 12 month period.

When a recipient is scheduled to be terminated from the waiver program, the service coordinator will send a notification (Form NMO-2734) to the DHCFP **Central Office** Waiver Unit identifying the reason for termination. The waiver unit will send a NOD to the recipient or the

October 1, 2015	HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR <b>INDIVIDUALS WITH INTELLECTUAL DISABILITIES</b> AND RELATED CONDITIONS	Section 2104 Page 2
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	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2104
MEDICAID SERVICES MANUAL	Subject: HEARINGS

recipient's legal representative. The form must be mailed by the DHCFP to the recipient at least 13 calendar days before the Date of Action (DOA) on the NOD. Refer to MSM Chapter 3100 for exceptions to the advance notice.

\*\*\*\*Service coordinators must track recipient stays in hospitals, nursing facilities, or ICF/IID's. Five days prior to the 45<sup>th</sup> day, the service coordinator will send a notification (Form NMO-2734) to the DHCFP Central Office Waiver Unit identifying the 60<sup>th</sup> day of inpatient status which is the termination date for waiver services.

Waiver slots must be held for 90 days, from the 45<sup>th</sup> day, which will be the date the NOD is sent to the recipient indicating termination or institutional placement, in case they are released and need waiver services upon release.

### 2104.3 REDUCTION OR DENIAL OF WAIVER SERVICES

Reasons to reduce or deny waiver services:

- a. The recipient no longer needs the number of service/support hours/days which were previously provided.
- b. The recipient no longer needs the service/supports previously provided.
- c. The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child.
- d. The recipient's support system is providing the service.
- e. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- f. The recipient has requested the reduction of supports/services.
- g. The recipient's ability to perform tasks has improved.
- h. Another agency or program will provide the service.
- i. Another service will be substituted for the existing service.
- j. The recipient has reached their service limit either annually or number of units.

	MTL 20/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2104
MEDICAID SERVICES MANUAL	Subject: HEARINGS

2104.4 REAUTHORIZATION WITHIN 90 DAYS

2104.4A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated due to placement in an institutional setting (hospital, nursing facility, or ICF/IID) the recipient may be eligible for readmission to the waiver if they have a discharge date and they request re-approval within 90 days of the NOD date (which is the 45th day).

The service coordinator must complete the following:

- a. Complete Form NMO-2734 indicating the date waiver services will begin again.
2. If a recipient has been terminated from the waiver for more than 90 days, they are treated as a new referral.

2104.4B PROVIDER RESPONSIBILITIES

ADSD will forward all necessary forms to the DHCFP Central Office Waiver Unit as required.

When a NOD is required to be sent to a recipient, the service coordinator will send a notification (Form NMO-2734) to the DHCFP Central Office Waiver Unit identifying a denial, termination, reduction, along with the reason. The DHCFP Central Office Waiver Unit will send a NOD Form, NMO-3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the NOD for a termination or reduction. Denials do not require 13 days.

There are no responsibilities for service providers.

2104.5 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.